Carter collected the cases reported to date. They were twenty-nine in number. The development of the condition seems to be about as follows: The child seems perfectly normal at birth. It continues to be normal for three weeks to a month, and then ceases to take any interest in its surroundings. It is often sleepless; it rolls its eyes more or less continuously, and is generally restless. When it should have strength enough to sit up, it fails to do so. It slides down on its back instead of sitting up, but does not fall forward or sideways. Vermicular motions in the fingers somewhat resembling the movements of athetosis have been noted. The tendency to somnolency becomes more marked. Hydrocephalus has been known to develop. Diplegia exists at times, and a spastic condition of the lower limbs has been noted. The electric reactions are normal. At the end of a year the child is totally blind, the optic nerve is of a dead-white color, more or less marked idiocy has asserted itself, and distinct palsy is present. Marasmus usually closes the scene before the end of the second year. The marked differential sign of the disease is the occurrence of idiocy in connection with blindness.

In a recent case seen by Dr. Claiborne the child was normal at birth and remained so up to the ninth month. Then an external squint was noted in the right eye. After this ptosis occurred in this eye. Then a similar train of symptoms developed in the other eye. The family history showed that the father died of tuberculosis. There was no syphilitic history, yet mercurial inunctions were tried on general principles, and after a while the ptosis disappeared and the squint was modified. Marasmus developed, however, and the intelligence decreased very markedly. As the malnutrition advanced the eye symptoms recurred, and finally death from exhaustion ensued. At the autopsy a tubercular tumor of the corpora quadrigemina was found. There was also generalized tuberculosis. Tuberculous nodules were found in the lungs, spleen, and the bronchial glands. Curiously enough this case was not of Hebrew origin. All the subjects of amaurotic family idiocy up to this one were Hebraic. In another case under Dr. Claiborne's care the subject was also not of the Hebrew race. The existence of the tubercle at the base of the brain is extremely interesting. It is possible that in most of the cases some such lesion has been present. At least it is suggestive to find that a tubercle can cause a set of symptoms that resemble amaurotic family idiocy so much.

The differential diagnosis is not difficult as a rule. Freidreich and Marie's ataxia in their hereditary form may be confounded. The pathogonomic sign is a condition of the fundus in the amaurotic family idiocy. The fact that death takes place from marasmus probably points to the tuberculous character of the affection. This characteristic has been missed so far because too much attention has been directed to the central nervous system, especially to the cortex. The suggested pathology of the disease up to this has been some disturbance of the cortex, while the ganglia at the base of the brain and the medulla were considered to be normal. Amaurotic family idiocy is evidently not so rare as has been thought. Seven cases have been under treatment at the Vanderbilt clinic. All of these were Polish Jews, and there was no history of phthisis or of consanguinity in the parents. JELLIFFE.

149 PROGNOSE UND THERAPIE GEHIRN LUES (The Prognosis and Therapeutics of Syphilis of the Brain). v. Hösslin (Deutsch. Archiv. f. klin. Med., Dec. 13, 1899, Vol. 66, p. 281).

v. Hösslin reports 11 cases with 2 deaths. The symptoms were various, some of the patients having attacks resembling epilepsy;

others having attacks resembling apoplexy and hemiplegia, and one patient, after apparent complete cure, developed paretic dementia a year later. Several of the others had slight relapses, which were readily amenable to treatment. In one very curious case the patient had multiple vanishing tumors of the scalp, that when excised were found to be due to syphilitic caries of the skull. The treatment consisted exclusively of inunctions of blue mass, potassium iodide by the mouth, and hot air baths. The latter were given at a temperature of about 120°. v. Hösslin calls attention to the great importance of feeding the patients in a state of coma through the esophageal tube. SAILER.

PATHOLOGY.

150 SUR UN CAS DE SOMMEIL PROLONGÉ PENDANT SEPT MOIS PAR TUMEUR DE L'HYPOPHYSE (A Case of Prolonged Sleep, of Seven Months' Duration, Caused by Tumor of the Hypophysis). F. Soca (Nouvelle Iconographie de la Salpêtrière, 13th Year, No. 2, March-April, 1900, p. 101).

A case of a woman 18 years old. No hereditary history, no syphilis or alcohol. Following an attack of sudden unconsciousness, symptoms of blindness, headache, and difficulty in walking developed. Vision rapidly disappeared. An ophthalmological examination showed almost no sight; a double optic atrophy, more pronounced on the left side, dilated pupils, not reacting to light; no ocular paralysis. Walking became impossible, and incessant vomiting, cerebral in type, developed. The most striking symptom after this was the tendency to sleep. Sleep seemed natural in every way except in point of duration. She could be roused with difficulty to take nourishment, but would immediately fall asleep again. This condition lasted seven months, during the greater part of which the patient slept. During her stay in the hospital pain and vomiting ceased. Patient died of broncho-pneumonia. Autopsy: The frontal and occipital poles of the brain were easily detached, but the base was held firmly to the skull by a neoplasm, which held the central part of the base of the brain to the dura mater. The tumor covered the sella turcica, situated directly in the tract of the first pair of cranial nerves. The olfactory peduncles were somewhat spread apart; they did not appear changed otherwise. The optic nerves, from the most anterior portion of the optic tract to the commissure, were adherent to the tumor, or rather so much a part of the tumor that they could not be distinguished from it. The tumor further extended posteriorly on both sides, involving the third and fourth pair, but no adhesions were present, and these nerves appeared in no way affected by the mass. The tumor was sarcomatous in type, possibly developing at the expense of the hypophysis. In discussing the clinical aspects of the case, the following general causes of prolonged sleep are considered: 1. Narcolepsy. 2. Hysterical somnolence. 3. Lethargy. 4. Catalepsy. 5. Natural and provoked somnambulism. 6. Coma. 7. Sleep due to various causes. In class seven, the author classified those cases which cannot be included in any of the others, and divided this class into two groups: those with no anatomical basis, and those with one. In the latter division the case described in the article is placed. Some consideration is given to the absence of compression symptoms in the third and fourth nerves and peduncles. The author finds the explanation in what he terms "the logic of multiple compression by a basal tumor." The effectiveness or the innocuousness of the compression depends upon two equally important factors: the push (poussée) of the tumor